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ABSTRACT

For Postpartum Education for Parents (PEP) volunteers, this reference guide provides background information about the common concerns of parents. Extensively reviewed for accuracy and content by pediatricians, psychologists, obstetricians, nurses, and childbirth educators, the guide contains a summary discussion of the postpartum infant and family. The guide is organized in a developmental format because the needs of parents and children vary greatly depending on the age of the child. In Section I, four chapters focus on physiological changes during the postpartum period, other changes during postpartum, the newborn, and special circumstances (such as adoptive parents, caesarean section, premature birth, multiple births, parents of handicapped children, parent-child separation, belated parenthood, and the single female parent). Topics discussed in the two chapters of Section II concern the emotional adjustments of parents and dimensions of children's development during the first year of life. The discussion of emotional adjustments describes parent's reactions, positive and negative aspects, and ways of dealing with pride, love, being needed, frustration, worry, jealousy, inadequacy, and resentment. The guide also contains a section on leadership and communication techniques and includes information on distinguishing between medical and non-medical issues. (RH)

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POSTPARTUM EDUCATION for PARENTS, Inc. of Santa Barbara

POSTPARTUM EDUCATION FOR PARENTS

VOLUNTEER'S REFERENCE GUIDE

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Jane Honikman
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Julie Armstrong

INTRODUCTION

Background and Needs

Postpartum Education for Parents (PEP) is an outgrowth of the Child Study interest group of the Goleta Valley Branch of the American Association of University Women (AAUW). As new parents ourselves, we realized that a couple may be prepared for childbirth, but may not be ready for the abrupt changes that occur when they become parents. Often frustrated by conflicting information and confused about whom to call for non-medical advice, parents find themselves needlessly alone. This is a time for reassurance.

We have found that there is very little information available that approached parenting by focusing on the parents. Such an approach should provide a forum in a non-judgmental environment which would promote the growth of confidence in parents to pursue and continue their own parenting techniques. We believe that this type of open expression and sharing of feelings and concerns can help to foster the personal adjustment that new parents must make.

Goals and Objectives

The purpose of Postpartum Education for Parents is to ease the adjustment of the postpartum family by offering non-medical advice and emotional support to all members of the Santa Barbara community. Our objectives are:

1) to increase the confidence of parents,
2) to assist the medical community at the para-professional level by decreasing the need for parents to call with non-medical concerns,

3) to establish a forum for parents to meet other parents,

4) to encourage the development of communication in the family unit and between people with similar problems,

5) to refer parents with special and/or medical concerns to professionals.

Services

Initial Contact

Contact with prospective new parents is made initially at prepared childbirth classes. Expectant parents who sign a Childbirth Class Summary Sheet then receive a Postpartum Telephone call from a PEP volunteer after their baby is born. PEP brochures are also distributed to postpartum patients in local hospitals. Professionals, physicians, and maternity nurses refer parents to PEP. Brochures are available throughout the community.

One-to-One Support

This service will be provided by a 24-hour "warm line" available to those persons desiring one-to-one sharing. Sincere emotional support from an objective listener is the primary purpose of this service, but questions dealing with basic infant care may also be answered.

Discussion Groups

New parent discussion groups will help deal with the emotional, psychological, and physical aspects of parenting. They will offer a time and place where parent and infant will meet and share the positive and negative experiences of parenthood. Volunteer leaders, trained by professionals to answer the most commonly asked questions of parents and to act as objective, non-judgmental listeners, will facilitate discussion in a casual and accepting atmosphere. These groups will provide an opportunity

for parents to discuss similar parental situations, learn possible solutions to problems, derive support from one another, and receive referral to more specialized help when necessary.

Special Circumstances Parent/Infant Assistance

When a special situation develops in the postpartum family, specially trained leaders will be available to provide emotional support and guidance. These volunteers are parents who have had a similar experience. Areas to be assisted are: adoption, birth defects, belated parenthood, caesarean section, infant-parent separation, multiple births, single parenthood, and premature baby.

About This Guide

This guide should serve as background in helping volunteers deal with the common concerns of parents. It contains a summary discussion of the postpartum infant and family including physiological, emotional, psychological, and developmental information on both parent and child. It is organized with a developmental format because the needs of parents and children vary greatly depending on the age of the child. It also contains a section on leadership and communication techniques and includes information on distinguishing between medical and non-medical issues. This guide has been extensively reviewed for accuracy and content by pediatricians, psychologists, obstetricians, nurses, and childbirth educators. It has been researched and written by the PEP Steering Committee.

SECTION I: THE POSTPARTUM PERIOD

The post(after) partum(birth) period is that time which encompasses the moments after the baby's birth, the days in the hospital, and the weeks and months of adjusting to the new role of parent. It includes the body in the non-pregnant state, regaining its physically normal condition, the initiation of lactation, the psychological adjustment to the baby, one's mate, and the role changes which occur in the family unit. Chapters 1 and 2 deal with these aspects of postpartum. Chapter 3 is devoted to a description of a newborn and basic infant care. The last chapter discusses a variety of circumstances which make the adjustment during postpartum particularly special.

Chapter 1: Physiological Changes During Postpartum Period

Involution

The involution process occurs when the generative organs return to the state they were in before pregnancy. Duration 6-8 weeks.

The Uterus - At the end of labor, the uterus weighs two pounds, reaches to just below the umbilicus and is fourteen times its normal size. In 6 weeks it has reduced its weight to only 2 ounces, and its size to its normal 3 inches by 2 inches by 1 inch. Most of this reduction occurs during the first weeks.

The Vagina - After labor, the vagina may be swollen, blue, bruised and pouting into the vulva. The tonicity of the perineum is reestablished

with surprising rapidity. Firming of the vaginal wall is greatly aided by the Kegal exercise.

The Lochia - The discharge from the uterus that is expelled through the vagina during the postpartum period is called lochia. There are three stages and durations of lochia:

1) 1-4 days - lochia rubra, a red vaginal discharge which may continue up to 2 weeks;
2) 4-9 days - lochia serosa, pinkish-brown;
3) 2-3 weeks - lochia alba, the discharge becomes white or yellow.

Lochia is largely composed of blood from the healing placental site and if the red discharge continues, or is profuse, it may be an indication of sub-involution or infection. An offensive odor is also suspicious.
On the tenth day, bleeding and cramping may occur as the uterus sloughs its scab. Three days of bleeding should be enough for this. For Ceasarean sections, the lochia may last longer since it takes the uterus more time to involute. In general, clots larger than a 50¢ piece and frequent should be checked by the doctor.

Reoccurence of Menstruation - For non-nursing women, menstruation may begin in 4-6 weeks after delivery. Breastfeeding mothers most commonly resume menstruation at 4 months with wide individual variations. The first menstrual flow is often heavier than prepregnancy; however, excessive bleeding may be an indication of postpartum hemorrhage. Contraceptives must be used immediately upon resumption of sexual relations by both nursing and non-nursing mothers to prevent pregnancy.

The Bladder - Large amounts of urine are produced during the first few days due to the discarding of the increased amount of blood plasma and

tissue fluid present during pregnancy.

The Bowels - The bowels tend to be sluggish during this time for two reasons. First, loss of fluids due to increased urination, perspiration and milk production. Second, the anus may be insensitive to stimulation having been forcibly dilated by the pressure of the baby's head. Often a laxative, enema or rectal suppository will be ordered before leaving the hospital. Increased amounts of fluids and added roughage in the diet will help.

The Skin - Increased activity of the sweat glands and capillaries of the skin is evidenced by profuse sweating at night or flushing in the daytime. This is normal and will cease within the first 2 weeks.

Temperature and Pulse - The temperature is variable during post-partum and may rise because of engorgement of the breasts, the discomfort of a full bladder or due to excitement, but such elevation is transient and should not be above 100°F. When milk comes in, usually about the third day, it is normal to see a temperature of 100°. However, a temperature over 101° after the third day should be referred to the doctor. The pulse rate should be slow. Excitement and fatigue may accelerate the pulse temporarily, but when the pulse and temperature are both increased, the possibility of infection must be considered. Completely relaxed breastfeeding mothers often experience slow pulse while nursing.

The Abdominal Wall - The muscles, overstretched during pregnancy and strained during labor, are slow to regain their normal tone and elasticity and require months of conscientious exercise to regain their former tone. Permission from the doctor should be obtained before exercises are begun.

The Breasts - During pregnancy, development and enlargement of the breasts has occurred in preparation for lactation. Lactation will occur several days after delivery, usually on the third, sometimes accompanied by a slight elevation in temperature. During pregnancy and until the milk "comes in", the breasts secrete colostrum. It is easily digested, nutritive, quenches thirst, is laxative in effect and contains immune bodies and vitamins. When lactation is not desired, hormonal suppressants may be prescribed, and tight supportive breast binders used.

Lactation

The process of lactation can be considered to take place in three stages: 1) the actual production of milk in the alveoli, 2) the flow of milk along the ducts to the nipple, 3) the withdrawal of milk from the nipple by the baby. The breasts are composed of glandular tissue which is arranged in approximately 20 lobes. Each lobe is divided into lobules which form the alveoli or milk-excreting units. The breasts are richly supplied with blood. Small lactiferous ducts, carrying milk from the alveoli of each lobe, unite to form larger ducts and widen before opening on the surface of the nipple to form ampulla, which act as temporary reservoirs for milk. Milk is formed as small fatty globules in the cells of the alveoli. It is pushed along the ducts towards the nipple by the milk which is being continually formed behind it in the alveoli. The act of sucking stimulates the production and flow of milk. This occurs as a result of a neuro-hormonal reflex; the stimulus of the baby's mouth on the sensitive nipple reaches the brain, and by nervous reflex, the hormones oxytocin and prolactin are released. They reach the breast in the blood

stream, stimulate the muscle cells to contract and cause more milk to flow to the nipple. This gives rise to the sensation know as the "let down". This can also occur when a mother, not with her baby, hears or sees another infant, or even from thinking about her baby. The emptying of the breast by sucking stimulates the glands to continue to produce more milk. Although the process of lactation may take place immediately, it will require a longer period of adjustment to completely establish breastfeeding.

Breastfeeding - There is a definite correlation between the physiological and psychological aspects of breastfeeding. The emotional state of the woman is closely related to how easily she will adjust to the role of the nursing mother. If, during the first weeks, the mother is able to feel relaxed and confident while nursing, the experience is apt to continue successfully. However, there are many contributing factors which may interfere with the relationship between mother and baby and result in an unsatisfactory breastfeeding situation. The first factor is the mother's self confidence in her ability to nurse. If she has doubts about the process, is physically uncomfortable, or if there are outside pressures against her nursing, her lack of confidence may result in failure. Occasionally the woman is prepared for nursing and then discovers that her baby may be either not interested or not able to suck as is necessary to stimulate the milk supply. Whatever the cause, a cycle of frustration between mother and baby may lead to emotional stress creating tension which inhibits the let down process. Lack of milk supply in turn means a hungry baby whose cries may make the mother not only irritable and fatigued, but feel that she has failed. To break this cycle, one suggestion is to provide the infant with a temporary supplemental bottle

after each nursing. Rather than diminishing her milk supply, this will allow the mother to reestablish her self confidence by providing the time needed to relax sufficiently to increase the milk available for the next feeding. Repeated stimulation will produce more milk, thereby satisfying the baby's hunger.

The nursing mother's diet is important. Therefore, a nourishing diet with plenty of liquids, proteins, vitamins and minerals should be maintained. Any drugs taken by the mother may affect her milk supply and may make the baby fussy. This includes birth control pills, diuretics, antihistamines and cortisone as well as too much caffein or too many cigarettes. In regards to medication, a mother should check with the doctor to find out if the drugs she is on will be harmful to the baby.

Another issue dealing with breastfeeding in our society is a possible feeling of self consciousness when nursing outside the privacy of one's home. There are a variety of ways to deal with the situation and each person must resolve this issue by assessing the time, place and company. Again, the factor of self confidence will help to ease this problem.

In other instances, there may be a baby whose demands to suck are so powerful that the mother feels as though she is nursing all the time. Feelings of entrapment may result, leading to further negative emotions. The key to solving this situation is the confidence to decide that what the mother does is her own choice whether it means weaning, supplemental bottle or baby-sitters. In many cases, this is a temporary problem due to growth spurts, but if it seems overwhelming then a solution to bring positive feelings back is essential. Emotional support from others who have experienced similar problems may be helpful, especially help from qualified leaders of La Leche League.

Immediate Discomforts During the Postpartum Period

After Pains - Following the birth of a first baby, the uterus generally stays in a state of contraction and the mother experiences no after-pains. After subsequent babies, the uterus does not seem to have the same muscle tone it possessed formerly and when the uterus contracts it is painful. The pains are like miniature labor pains that come and go, spasmodically, during the first week. They are often more acute while the baby is suckling, thus hastening the involution of the uterus. They can be dealt with in the same manner as labor contractions, with relaxation and deep breathing.

Stiches from an Episiotomy - An episiotomy is the enlargement of the vulval orifice by perineal incision. It is performed to minimize the risk of a perineum tear. Keeping the stitched area clean, sitz baths, heat lamp, use of hospital-supplied topical anesthetics and witch hazel on sanitary napkins will ease discomfort and hasten healing.

Sutures disolve in 18-20 days. Additional care may include the use of Vitamin E. A&D ointment or Vaseline are helpful in keeping urine away from incision which causes a burning sensation. After the third day, the episiotomy should get less sore. Any bleeding from the incision should be checked by the doctor.

Hemorrhoids - These are varicose veins of the lower rectum and anal canal or orifice. With the pressure of the baby's head on the anus during the perineal phase of labor, hemorrhoids sometimes prolapse and give rise to pain and discomfort. Application of ointments and warm water may help, as will a diet with plenty of liquids and low in roughage.

Initial Tension of Engorgement of the Breasts - 1) Nursing mothers. This is a condition, varying in degree from slight to severe, commonly occurring between the third and fifth day of postpartum. The breasts are full, heavy and hard due to venous and lymphatic engorgement and edema, and not due to an abundant supply of milk. The muscular mechanism by which milk is expelled is inhibited and, when the breast tension rises excessively, the cells cease to produce milk. To treat, apply moist heat to breasts before feeding, nurse frequently and hand-express remaining milk. Breasts will become very pliant after initial engorgement but this does not mean that there is not enough milk.

2) Non-nursing mothers. To relieve the heaviness and discomfort of non-lactating breasts, an analgesic, ice packs and breast binders are effective. For mothers with heavy pendulous breasts, a good supportive bra is important.

Later Engorgement - This may occur from incomplete emptying of at least one breast at each feeding or going too long without nursing. This condition may be helped by nursing frequently from both breasts and applying moist heat to breasts before feeding to encourage let down. It may be necessary to hand express enough milk prior to nursing so that the baby can adequately hold on to the nipple.

Sore Nipples with Initial Nursing - This occurs when the baby is first put to the breast and lasts until the nipples have adjusted to the sucking of the infant. Nipple preparations, such as creams, may ease this discomfort somewhat. It will happen with each nursing experience since the nipples return to their normal state after weaning. Additional sug-

gestions for care are dry heat, airing and lanolin. Soap and alcohol are not necessary. Most ointments recommended for nipples are not harmful to the baby. Try nursing more frequently for shorter times, or holding the baby in different positions. A nipple shield may help.

Futher physical problems with breasts should be discussed with the obstetrician. If cracks or bleeding occur, consult the doctor at once.

Resuming Sexual Relations* and Contraception - Unless there are medical or personal considerations, a couple may resume intercourse about three weeks after either a vaginal or Caesarean delivery. (Orgasm not only stimulates the milk let-down reflex but encourages involution of the uterus.) Due to progesterone dominance so long as a mother nurses, some women may need a water soluble vaginal lubricant such as KY Jelly (not vaseline). When intercourse is resumed effective contraception must be used, whether or not the mother is nursing, if the couple does not wish to conceive. Decisions about family planning methods are best made during these early weeks, based on advice from an obstetrician or other qualified counselor. Choice of method is an individual matter; factors to consider are comfort, cost, convenience, personal preference, possible health risks, and effect upon the couple's sexual relationship. Contraceptives vary in degree of effectiveness; success depends on correct and consistent use, although none is foolproof. Improper use or method failure may result in an unplanned pregnancy; this possibility might need to be weighed against the advantages and disadvantages of the method selected. Couples should educate themselves about currently available contraceptives to make an informed and appropriate decision.

*see also Role Changes, p. 16

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NOTES

1) "Postpartum Blues...As Natural As Childbirth" Ms., by the Boston Women's Health Book Collective, March, 1976.

Chapter 2: Other Changes During Postpartum

A woman's nervous system experiences change as a result of labor and delivery just as her body has been depleted of physical energy. A process of emotional adjustment occurs in the same way that involution takes place. It encompasses several stages:

1) Immediate postpartum feelings last the duration of the hospital stay from delivery to approximately three days. They incorporate a wide range of emotions: happiness, pride, relief, excitement, disappointment, weariness, discomfort. A "low" feeling may occur by the third day and is usually accompanied by the onset of milk production. This may be the result of sudden hormonal changes in the body. It may also have to do with the realization that the 9-month preparation for birth is over and with it the full impact of the baby's reality.

2) The second stage begins upon the return home from the hospital and may last from one to three months and deals with the actual coping at home. It is closely related to the woman's physical condition, fatigue in particular. It includes: a) stress of incorporating a new person into an existing family, b) changing relationship with one's mate, and c) constant demands of the infant. This time may be one of heightened exhaustion, fragmentation, disorientation and chaos.

3) The last stage comprises the long-term adjustments of becoming a parent. It may last up to one year or more. The decision to become pregnant means an involvement and commitment to change one's life. Expectations, childcare ideas, methods, and philosophies vary and may bring on clashes between family members. Also, financial strain, continuing

fatigue, and acceptence of unfamiliar roles add to potential areas of conflict.

It must be emphasized that the variation, duration and intensities of these stages are great and that no two people will experience the same type of adjustment.

Theories and Recognition of Acute Postpartum Disturbances

Traditional Theory - The "traditional" and first serious theory was that women who suffered from severe postpartum depression had deep-seated mental illness and that birth of the baby was merely the trigger that brought the pre-existing psychic disturbance to the surface. This theory is approximately thirty years old. Today, the psychological explanation is sometimes supplemented by stress-triggering theories.

Physical Stress Theories - In 1962, a study found postpartum depression analogous to combat fatigue, hormonal imbalance and the bodily shock of labor. Treatment emphasizes drugs, hormones and sometimes hospitalization in severe cases.

Social Stress Theories - Other reports show that the social factor including background and current environment, can be major contributors. Reports of depression in fathers and adoptive mothers indicate that the causes are not purely physical.

Manifestations of Postpartum Disturbance

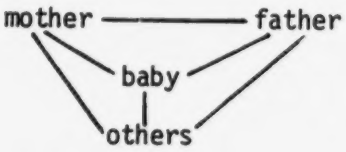
A potential case of acute disturbance occurs when the common feelings of the postpartum period persist and are associated with unremitting lack of interest in the infant. Serious depression goes on and on. Characteristically, the symptons of the severely affected mother include

weakness, apathy, insomnia and loss of appetite of libido, and withdrawal. Withdrawal is another sign of an acute case. At this point a woman may need professional help. A volunteer should allow for expression of feelings, (What were the expectations? Does Father help? What it the mother's support system? What is husband/wife relationship?)

Coping With Postpartum Changes

Suggestions for dealing with some of the aspects of physical and psychological changes during postpartum are listed below:

1) Build up confidence in ability to care for baby by reading and discussing questions with doctors, hospital staff, friends and family.
2) Get extra help in the home from husband, relative, friend or others.
3) Get sufficient sleep, rest, good food, recreation, tranquility.
4) Eliminate or minimize visitors, both family and friends.
5) Show encouragement, patience and understanding toward one another in the family unit.
6) Share baby care from the very beginning with joint responsibility, not just division of tasks.
7) Divide time providing a balance between each person in the family unit:



8) Avoid isolation, but respect privacy.

9) Provide mother with time to pursue own interest outside parenthood responsibilities.

10) Have open discussion of feelings, private or group.

11) Seek professional help when unable to deal with physical or psychological questions or problems.

Emotional Adjustments

These and other emotions are normal feelings which may or may not be experienced by parents. They vary in intensity and duration.

Mother	Common Feelings	Father
physical demands are difficult to meet; sense of responsibility toward baby	OVERWHELMED	more complicated life style; mate more demanding
new dimension of feelings toward mate, baby	LOVING THANKFUL	new dimension of feelings toward mate, baby
inexperienced; fearful; lack of confidence toward new responsibility	PANIC	financial worries; inability to handle baby
baby's cries, short sleep schedule; no time for self; mate not helping	IRRITATION	demands by baby, mate; crying; interrupted routine
sense of accomplishment; new challenges	EXCITED SATISFACTION	new challenges; we did it
result of birth; increased work load; excitement	TIRED	change in life style; new demands of family

Mother	Common Feelings	Father
complications from birth	PAIN	
hormonal changes; mate insensitive; birth discomforts	SEXUAL FRUSTRATION	result of birth; baby in the way; mate not sexy
inexperienced with baby; not appealing toward mate	INADEQUATE	afraid to handle baby; not sure of mate's feeling
societal pressure on motherhood role	INSECURE	societal pressure of being a father; increased financial burden
change in routine; no help in home; duty to be fulltime mother	TRAPPED LONELY	sense of duty to help; no social life
attention focused on baby; mate not helping	RESENTMENT JEALOUSY	attention on baby; mate too demanding
natural result of birth; inability to cope; hormonal	DEPRESSED WEEPY	inability to deal with mate; can't cope with change

Emotional Adjustment

Parents must feel comfortable with and accept their feelings if children are to learn to do the same. Husband and wife should take time each day to talk with each other about their feelings. Parents should be encouraged to talk out loud to baby while performing tasks and express what they are feeling.

Role Changes

Becoming parents brings about changes within the family unit. If this is the first baby, it marks a change in the relationship between the couple which includes emotional adjustments towards each other and towards the baby. It also includes a temporary sexual adjustment period. If siblings are included in the family, then their feelings must be considered, as well as the parents' attitude towards each child as an individual.

It is important to realize how stressed a relationship with one's mate can become during postpartum. Feelings towards each other range from jealousy and inadequacy to increased love and respect, from feeling neglected to totally ambivalent. Expressing any feeling verbally is essential in attempting to deal with this adjustment time. Discussion groups or private conversations may be helpful in recognizing that these types of emotions are common and normal. Once out in the open, and discussed at the best time for both persons, they can be dealt with and understanding can be achieved.

Sexual relations change. Some women may have little or no interest in sex. This may be associated with lowered estrogen levels in the body. This is fairly common, does not indicate "frigidity", and may be more prevalent in nursing mothers. Resumption of intercourse may occur at three weeks if there is no adverse physical reason; however, discomforts from stitches and/or low sexual interest may require a longer waiting period. Remember, too, that sexual expression need not always include intercourse, and expression of affection need not always include sex. Reliable birth control methods must be used from the time one begins intercourse again.

Open communication between mates is the best way to achieve mutual understanding.

Feelings toward subsequent children may include the following: a) guilt that the older sibling will suffer from lack of attention, b) fear that jealousy toward the new arrival will exist, c) fear that rivalry between siblings will occur, d) resentment about change to an existing family unit, e) joy in sharing the pregnancy with the older child, f) excitement in anticipating the increased challenges of a new family unit, g) determination to do it "right" this time. Advanced preparation will ease this aspect of the adjustment period. Older children should be aware of the pending birth, be given correct answers to their questions dealing with conception, pregnancy and birth. They should be involved in preparations for the arrival, and be given additional attention in some form by the mother, especially after the birth. Possible feelings of jealousy and/or anger should be mentioned. An explanation that it is okay to have these types of feelings may help the child to express these emotions in a constructive manner. Stressing the positive side of being older is helpful as well as adding reinforcement toward feeling good about the baby.

The relationships with extended family members will also change. Although well-intended, relatives often give too much advice which may be incorrect, outdated or biased. Also, their repeated physical presence may become a burden. Therefore, it is important for the parents to determine what they find helpful and to have the confidence and strength to handle whatever is burdensome. The parents who find it difficult to reject this help whould decide that their first concern is the wellbeing of baby, mother and father.

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NOTES

1) "Postpartum Blues...As Natural As Childbirth", Ms., by the Boston Women's Health Book Collective, March, 1976.

Chapter 3: The Newborn

Appearance

Size - Boys at birth weigh, on the average, about 7½ pounds, girls about 7 pounds. The limits of varibility are wide, and entirely normal babies may weigh as little as 5 pounds, or even less, and as much as 10 or 12 pounds. The infant loses weight during the first three or four days after birth. The weight loss usually amounts to 5% - 8% of the birth weight. The baby usually starts to gain on the third to fifth day of life, depending on his food intake. Breastfed babies may lose more weight than bottlefed babies and may take longer to regain weight loss.

Fontanelles and Head - In a baby, the bones of the skull are not joined as in an adult but are held together loosely by membranes. Residual molding from birth process can last several months. Scalp can appear swollen. There may be scratches from monitoring or membrances being ruptured (usually gone in 24-48 hours.) Cephalohematoma is the swelling and breakage of blood vessels on both sides of the crown. This may last 3-4 months. The bones are separated by open sutures which permit further growth of the skull. In young babies, these two fontanelles or "soft spots" may palpitate, i.e. beat rapidly and strongly. The posterior fontanelle is small and generally closes at about six weeks of age. The anterior fontanelle is variable in size. It usually closes at about one year to 18 months of age, but the time varies greatly. The head may be greatly distorted at birth (molding), but this corrects itself in a few days. In a certain number of instances the distortion in the head shape is caused by the way the fetus lies in the uterus. In these cases, the head remains asymmetrical for months, but here too, spontaneous correction

takes place.

Eyes - At birth the eyes are ordinarily slate gray or blue. They assume their permanent color at about three months, but changes may occur up to the first birthday. Tearing of the eyes is usually absent until about six weeks of age. In some instances, tearing of one eye develops several weeks after birth. Excessive tearing, however, should be brought to the attention of the baby's physician. Eyes may be weepy and swollen from silver nitrate solution. They should be okay in 2-3 days. Newborns see poorly (20/800) and can see shapes but not distinguish people. At six months, vision has improved to 20/60.

Skin - The skin of the newborn is bright red owing to the large number of red blood cells and the large amount of hemoglobin. The hands and feet may be bluish but this disappears in a few day. At birth, the skin is covered with a whitish material called vernix caseosa. This material serves as a protection for the skin while the baby is floating in amniotic fluid during prenatal life. Normal skin of a newborn can be flaky, but lotions are not usually needed. Jaundice is caused by the breakdown of red blood cells which the liver is too immature to handle. Detection can be done by blanching the skin in window light. Especially if there is a yellowing detected on the legs, the baby should see a doctor immediately. More breastfed babies become jaundiced because of greater weight loss and it takes more time to balance the liver function. A couple of days after birth there may be a touch of jaundice, which is a yellow discoloration of the skin, eyes and membranes of the mouth. It begins to disappear about the fifth day and is usually gone before the end of the second week. Jaundice should be reported to the physician. Often there is a growth of fine downy hair over the body called lanugo. This is apt to be profuse in prematures and entirely absent in postmaturely born babies. It disappears within a week or two. Birth-

marks are found regularly on newborns. Those which occur normally are flush with the skin, bright red, and are seen on the upper eyelids, on the forehead, the back of the head, and the neck in the center line. They generally disappear before the end of the first year. Occasionally they persist for a few months longer. The spots at the back of the neck are sometimes referred to as "stork bites". Small raised whitish pimples are often seen over the nose of the newborns. They are of no significance. Occasionally pimples with blackheads (acne) occur. They last a few weeks and disappear without treatment. The newborn has very sensistive skin and reacts with rashes to all sorts of irritants. These rashes are best treated by avoiding overdressing, prompt changing of diapers, or applying the various ointments your physician would prescribe.

Motor Status

The motor activity at this age is primarily reflexive, and movements are, for the most part, random. Trembling of the chin is frequently seen in normal newborns. Other reflexes present in the newborn are sucking, swallowing, coughing, gagging, winking, yawning, and rooting. If an object is placed in the baby's palm, he grasps it firmly. This grasp is also present in the feet. However, this reflex is not to be confused with the Babinski reflex which is characterized by a fanning out of the toes when the bottom of the foot is stimulated. The Moro reflex is also very common. It is caused by a sudden change of position, jarring, or sudden loud sounds. The infant throws up his arms in an embrace attitude and the legs are sharply flexed, usually followed by an explosive cry. If the Moro reflex is extreme, swaddling the baby is a good idea. The stepping, or "dance" reflex

occurs when an infant is supported in a standing position. The tonic neck relex is a posture resembling a fencing position: on his back, the infant's head is turned to one side, one arm extended, the other arm flexed.

Sensory Status

Babies can see at, or shortly after, birth. They can discern between light and dark. In the early weeks they are able to fix on an object that is near. Initially many infants experience difficulty in coordinating their eyes efficiently. While this "cross-eyed" appearance is a source of new-parent concern, the muscles gradually develop more coordination and the condition usually self-corrects by four months. At birth the cavity of the middle ear is filled with fluid. This is quickly absorbed, after which newborns hear. Sound is meaningful to them. They are disturbed by abrupt, loud sounds and are quieted by the cooing voice of the parent. Taste is present in the newborn, as is smell. The sense of balance (kinesthetic) is well developed. Abrupt changes in position or loss of balance lead to crying, while gentle rocking movements can be quieting. All skin and internal sensations are experienced by the newborn and it reacts emotionally to all stimuli. Disagreeable situations - abrupt loud sounds, sudden changes in position, a cold object applied to the skin, restricted movements in an uncomfortable position - cause the infant to react by crying, tensing the muscles, and sucking the fist or fingers. On the other hand, soothing stimuli, like rocking, cooing, snug holding, warmth, stroking the skin, lead to quiescence, a general muscular relaxation and stretching movements.

Body Functions

Respiration - Slow, irregular, superficial breathing movements are made in utero. The birth cry is usually the start of postnatal breathing, caused by sensory stimuli of exposure at birth. Irregular respirations are normal in an infant, so long as its color is okay. They are more rapid in infants than in adults. Hiccups are common but they disappear promptly after a few sips of water. Sneezing, also common, is the only way the baby has of getting material out of its nose.

Digestion - The sucking reflex is present at birth in full-term babies, and the swallowing reflex goes hand in hand with the sucking reflex. Spitting up is common in newborns. It may be due to the swallowing of a great deal of air, giving too large or too frequent feedings, or failure to allow burping of air during feedings. Vomiting, or the forceful expulsion of food (projectile), is less common than regurgitation (spitting up.) Projectile vomiting should be reported to the physician promptly if it continues. While some babies never spit up, others do and may continue to do so for up to one year. Both types of babies are normal.

Elimination - 1) Stools. During the first two or three days after birth, the stools are dark green in color, sticky, and odorless, and are known as meconium stools. They consist of intestinal secretion, material swallowed before and during birth, mucus and bile. The transitional stool is loose, slimy and brown to yellow or orange and lasts three to four days. Breastfed stools are more frequent, mucoid, squirty and yellow than bottlefed stools which are seedier, and fewer. Formula-fed babies' stools are firmer and less frequent. Frequency and consistency varies depending on the baby and whether it is breastfed or bottlefed. Some fussing or crying related to

bowel movements is common. Iron in formula can cause constipation. If baby is uncomfortable from gas caused by constipation, water or very diluted prune juice can be given. Signs that baby has constipation while being bottlefed are straining and very hard stools. Breastfed babies' milk is so fully absorbed, it is not uncommon to see fewer stools, however, baby will be gassy and fussy if constipated. In the case of diarrhea, stools are doubled and diapers are soaked. It is frequently accompanied by other symptoms.

2) Urine. The first urine passed by the baby is scant and clear. During the next few days, the urine is concentrated and darker in color. Elimination is a good indication of intake. In breastfed babies, six to ten good wet diapers per day is evidence of sufficient intake. If urination frequency falls off, water after a nursing is a good suggestion.

Sexual Systems - 1) Genitalia. The genitals of both newborn boys and girls may be puffy and swollen. If a baby boy's scrotum continues to look swollen after a week or two, the physician should be notified.

2) Vaginal bleeding. A small amount of vaginal bleeding, sometimes referred to as pseudo or false menstruation, is seen in about 5% of newborn girls. It is normal and need not cause concern.

3) Breasts. Every normal newborn should have some palpable breast tissue. This condition may persist up to six months of age. Also, during the first three weeks of life a milk excretion (witch's milk) occurs in both boys and girls, and is due to the transfer or hormones from mother to child during prenatal life. It diminishes after two or three weeks, but occasionally lasts up to three or four months. Do not squeeze or massage or apply ointment to the infant's engorged breasts.

Other Body Functions

1) Sleep. There are as many patterns as there are babies. Sleep may be light and readily disturbed. The infant may awaken with a sharp cry and lapse back into sleep after a feeding. Infants may need to cry themselves to sleep, and they may sleep very much to very little. Changes in position, rocking, etc., may improve sleep. The parent should waken the sleepy newborn (up to several months) after a maximum of five hours of sleep for a feeding.

2) Crying. Newborns spend a considerable part of their waking time crying. Some of the reasons for this are hunger, gas, vomiting, and wet diapers or even temperature changes. A baby who cries persistently during the first week or so is probably hungry. Feeding every hour the first week is okay. After that, feedings should be spread to 2½-3 hour schedule. In many instances, the cause of the crying is unknown. Tending to the baby's needs by rocking, walking, singing, etc. will not spoil the baby.

3) Colic. Colic may be another cause of crying. It is important that the physician distinguish between colic, which is common, and more serious gastrointestinal problems. A more complete discussion of colic may be found under Health Care and Illness. The tendency is to feed colicky babies more often. Instead, try some of the following: warm washcloth on tummy, soaking in warm water, pacifier, water between meals, swing, or more frequent nursing for sucking. Biggest upset is usually late afternoon, early evening when baby is tired and mother has less milk. Mother should try pumping breasts so that father could give bottle at this time. Other suggestions are: wine or beer for mom, peppermint tea for baby (steep to color of pale urine, give one ounce warm, to baby.)

Care of the Newborn Child

Feeding

1) Breastfeeding. Successful breastfeeding depends on the physical and emotional well being of the mother, and upon the development of a successful "technique" for feeding. A few suggestions to help new mothers establish such a technique are now offered: a. Nursing time should increase gradually with the duration and frequency of feedings varying with the child and the child's need to suck. b. In the first few weeks it is not advisable to allow baby to sleep through feedings. This inhibits the establishment of a milk supply. Lower birth weight infants, in particular need to be fed at more regular intervals. If the baby wants to sleep during feedings, stimulate by gently jostling the baby or by applying a warm wash-cloth to its face and head. c. Babies have a natural rooting reflex. A gentle touch on the baby's cheek will cause its head to turn toward the breast. d. The baby should take the entire areola in its mouth. Sucking or chewing on the nipple will not produce milk, just nipple soreness. e. Always break suction before removing baby from the breast. f. For a baby who sucks too vigorously when fed, try nursing more frequently for shorter periods. g. If soreness occurs try changing the position of the baby on the breast. h. Make sure both breasts experience complete emptying. Mothers frequently use a safety pin on their bra to mark the breast which was last nursed so that the baby may begin on the same one next time and thus insure a complete emptying of that breast. i. A fussy baby does not always mean a hungry baby. Growth spurts occur at about 2 to 3 weeks, 5 to 6 weeks, and 2½ to 3 months. The baby may need to nurse more frequently and/or for longer periods during these spurts. j. Should weaning be necessary during this

period, a slow conversion to the bottle is best for both mother and baby. If breasts are uncomfortable, baby may be allowed to nurse for a few seconds. Bind breasts around the clock, take aspirin for discomfort. k. Breast milk can be frozen up to six months. l. Electric breast pump is available at Goleta Valley Hospital at all times. m. Breast cups are okay to use but not for storing milk. n. In cases of medication and breastfeeding, consult the doctor.

Any special problems concerning nursing are best discussed with the doctor or referred to La Leche League.

2) Bottlefeeding. Holding baby for its feeding offers the baby emotional and physical stimulation and support; because of this, propping bottles should be avoided. When giving the baby its bottle, the bottle should be tipped so the nipple is filled with milk. That way, less air will be swallowed. Read the directions on the formula can, diluting concentrated formula but never diluting ready-to-feed formula. Follow the doctor's advice as to how much and how often to feed, get formula mixing proportions from the doctor. It is okay to store a maximum of 48-hours in refrigerator. Steralize water if from a well. No need to sterilize bottles or nipple. Formula can be reused if refrigerated right away but it loses viatmins within 24-hours. Wake a sleeping baby after five hours (up to two months of age) to feed. Problems should be discussed with the doctor.

3) Other liquids. Water may be offered between feedings. Infant preferences for water vary greatly. Some parents add a sugar (syrup-4 ounces water to one teaspoon sugar) substance to the water. Some doctors start diluted juices within this period.

4) Solid foods. Solid food may be introduced at the doctor's discretion, depending on the child's needs. Foods should be introduced one at a time, starting with small amounts and increasing gradually.

5) Burping. Techniques for burping: hold baby firmly against your shoulder and tap or stroke on the back; lay baby on her tummy and gently pat on the back; sit baby upright, supporting the head by resting the chin on a V formed by your thumb and forefinger, and pat gently on the back. It is important to relax the baby, and not attempt to stimulate a burp. The frequency varies with each child.

6) Scheduling. At first newborns will want to eat every two or three hours, but soon will average out to every four hours. However, this is strictly the average, and there are wide variations among babies. Wake a sleeping baby after five hours (up to two months of age) to feed. A pacifier may be used between feedings to content a fussy baby and lengthen feeding intervals. "Nuk" pacifier is recommended by children's dentists; however, the child may have a definite shape preference of its own. Bottles of water may also be used for this purpose. Colic may affect scheduling and cause problems which may be initially interpreted as feeding problems. This should be discussed with the doctor.

7) Formula to breast? Does the mother really want to? Discuss with the doctor. Even if she has had medication to dry up breasts, it can be reversed (using father to stimulate breasts.) La Leche League is good support in this circumstance.

Daily Care - 1) The navel. Until the cord dries up and falls away, rubbing alcohol should be applied lightly with clean gauze at most diaper changes. Using cotton balls is a mistake as they may stick to the

cord and may cause infection. Sponge baths should be given until the cord falls off. Keep the cord dry with the undershirt rolled up and diaper rolled down. Occasional blood specks on the navel are normal. Foul smelling umbilicals should be reported to the doctor. Hernias just above the navel are not unusual and heal up almost 100% of the time by themselves. They should be checked by a doctor. Do not cover the hernia with coins or tape.

2) The circumcision. Some hospitals use a plastic ring which comes off naturally at about ten days or earlier. It should fall off of its own accord. Some circumcisions bleed. This is normal and not cause for alarm. Remove gauze and clean to be sure there is really bleeding. When the baby is new, vaseline and gause can be put on the head of the penis for protection. Be sure to clean (alcohol) as bad odor develops. Bloody discharge is sometimes due to not changing the gauze frequently enough. Change, clean and watch to see if there is actual bleeding.

3) Outings. Common sense dictates that parents take such precautions as warming up the car first during cold weather. Newborns should not be in the direct sun. Avoid overdressing the baby in warm weather.

4) Bathing. Equipment should be laid out in order of use in a warm place free of drafts. Diaper pins may be pinned on the mother's clothes to avoid losing them. After testing the water to make sure it is not too hot, the baby should be washed quickly. Do its head and face first, with its body still wrapped in a towel. Cleanse its eyes from inner eye out, using a fresh cotton ball for each wipe. It is not necessary to bathe the baby daily except for its face, hands, head and buttocks. Washing the scalp every day may worsen dry skin. A weekly shampoo is probably sufficient.

5) Room temperature. Temperature of baby's room should be constant, avoid drafts and extreme heat. 70^{o} is okay for the first few weeks.

Health Care and Illness 1) Colic. Colic is characterized by sharp pains in the intestine that are associated with hard crying periods that regularly occur after one feeding time (usually evening.) The baby's abdomen becomes distended with gas, he pulls up his legs, has a red face, screams piercingly for very long periods of time, and he may pass gas by rectum. These symptoms may begin between two to four weeks and are usually over by three to four months. They may be caused by fatigue or an immature digestive or nervous system. If colic is suspected, the doctor should be consulted and he may prescribe a sedative or other useful aids such as a change in formula, a pacifier, hot water bottle (warm not hot), bubbling, rocking, or having the infant lie on its stomach on the mother's lap while she pats its back. Most babies with colic gain weight and are otherwise healthy. If the infant has severe crying that does not have the characteristics of colic, the doctor should be notified since this may indicate some other condition that requires treatment.

2) Rashes. For diaper rashes, the diaper should be changed often and plastic pants avoided. Exposure to air, when possible, is also healing. An ointment such as A & D, Desitin or Vaseline, may be used unless otherwise directed by the doctor. Diaper washing techniques should be checked since rashes may be aggravated by inadequate rinses or harsh soaps. For other rashes or prolonged severe diaper rash, call the doctor.

3) Normal temperatures.

Oral	98.6° F.
Rectal	99.6° F.(1° higher than oral)
Axillary (under arm)	97.6° F. (1° lower than oral)

Temperatures are not a very good indication of illness in the first six weeks. The infant may be very ill with very little fever. Doctors do not ask parents for the baby's temperature at this age. A good indication of baby's health is the baby's behavior and appearance.

4) Nasal Congestion. Congestion and dried mucous in the nasal passage are common causes of "noisy breathing" in the infant, especially during winter months. Extremely dry air may make both breathing and feeding difficult. A humidifier or vaporizer in the baby's room will add much needed moisture to the air. Even a bucket of water in the room will help if finances are a problem.

5) Cradle cap. This is a mild disorder of the scalp common in the early months and occurs when the top of the scalp does not get enough friction for the dead scales to rub off. Cradle cap is the accumulation of these scales and appears as dirty looking scaley patches on the head. Some doctors recommend using baby oil or mineral oil to loosen scales prior to washing. Frequent brushing of the scalp helps. If scaliness is more extensive than just the top of the head, check with the doctor.

6) When to call the doctor. If the parents have not already done so, they should check with the baby's doctor concerning his specific guidelines for telephone calls. Some doctors have very explicit rules for describing when they should be called. Generally, if a baby is happy, eating his food, gaining weight, and sleeping at night, then all is well

with him. Losing his appetite for one meal, vomiting once, crying for half an hour, or a slight sniffle should not worry the parent nor cause a call to the doctor. However, seek advice without hesitation in the following circumstances: a. Baby behaving oddly - listless, drowsy, or irritable, loss of appetite, screaming which cannot be comforted - apparently in pain; b. Baby looking oddly - pale, blue, yellow, flushed, watery or glassy appearance of the eyes, soft spot in head sunken; c. also for convulsions; diarrhea - more than several loose movements in an infant whose stools have previously been formed (in breastfed babies when frequency is double normal); vomiting - if it is persistent; cough - which is more unusual in infants; injury to the head, if the baby is not normal and happy within 15 minuted; hoarseness in crying; fever - if the child seems really sick; rash - if it is extensive or child seems sick; colds - if it is the first one, or if there are complications.
Whenever there is a high degree of anxiety on the part of the parent regarding the baby's behavior. PEP volunteers should not call the doctor for the parent without the parent's permission.Calling the hospital nursery is a good suggestion.

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Chapter 4: Special Circumstances

Adoptive Parents

In cases where a family unit is created through the adoption of a baby, the postpartum experience will be similar to that of the natural parent. Although the biological aspects of this period do not apply, comparable efforts have been extended in order to achieve the goal of parenthood. In contrast to a known waiting period of approximately nine months, the adoptive parents may have been waiting for many years to bring their baby home, and then the arrival may be quite sudden. The psychological ramifications vary, but this first stage of the postpartum brings the same wide range of emotions as that of the natural parent (see page 11). This stage will begin with the notification of baby's availability and continues through final preparations, initial meeting, and concludes with homecoming. First stage feelings may include panic because suddenly a final decision must be reached regarding the adoption. This panic can lead to doubts about the decision to adopt; a feeling of guilt may then arise. Second and third stages can be considered the same as for natural parents including fatigue, even though the mother is not physically recuperating from delivery. An added dimension to the second stage adjustment phase of learning to cope with the reality of parenthood, is pressure from persons who say that it must be easier for the adoptive mother who isn't tired from giving birth. She is apt to feel guilty when hearing this since she is indeed emotionally exhausted as well as tired from lack of sleep. Gaining self-confidence is the key to adjustment, and discussions with other adoptive parents will aid in the process.

Caesarean Section

The postpartum period for the family who has experience the birth of their baby by means of a caesarean section will include additional physical and psychological aspects compared to a normal delivery. For the couple who has prepared for a normal delivery and is surprised by the sudden need for surgery, the feelings of letdown, failure, or disappointment may occur. The mother may be resentful that her husband is able to know the baby's sex and see or hold the baby first. Her psychological state is complicated by the physical stress she has undergone through a possibly long and/or difficult labor and then major surgery. Relief may accompany or over-ride these other feelings. The recovery period varies with each patient and may have a direct relationship to her state of mind. Reinforcement may be necessary to assure her that she has not failed because the baby was not born vaginally. If the mother plans to nurse, additional encouragement during the hospital stay may be required to achieve the goal. As with normal deliveries and adoptive parents, the three stages of postpartum psychological adjustment are comparable (see page 11 .) However, since the mother has just had major surgery, the transition period between hospital care and return to the prepregnant state may require additional assistance for the mother with the baby and/or housework until she has regained her strength. Fatigue will compound emotional problems as in every case of parenthood adjustment.

Premature Birth

The postpartum period for the family who has a premature baby will have added psychological dimensions. Initially, in place of the hap-

piness, excitement, and fulfillment experience after the birth of a full term infant, the parents of a premature baby will feel anxiety and fear for their baby's life. There will also be disappointment at not being able to hold or nurse the newborn immediately in the hospital.

The second psychological stage during postpartum, the return home from the hospital, is especially significant for the parents of a premature infant, particularly for the mother. The physical well-being of the infant requires that it remain in the hospital. The bond between parent and child that is created early by physical contact is thus necessarily delayed following a premature birth. The mother may experience extreme feelings of depression and disappointment, may feel that she has deserted her baby, that after many months of pregnancy she cannot be a "real" mother to her baby. She will need sympathetic support and understanding during this period. Hopefully, the pediatrician and hospital staff will encourage daily visits where parents are allowed to hold, rock, and feed their baby.

Breastfeeding is possible with premature infants, but it does require great determination and effort on the part of the mother. The infant may not be strong enough for the vigorous sucking that breastfeeding requires until he weighs seven or eight pounds. It is possible to express breastmilk by hand or with a breastpump, and it can then be given to the baby in a bottle with an especially soft nipple. The mother should be encouraged not to feel she is a failure if she is unable to nurse.

When the baby does come home from the hospital, the parents are likely to feel protective and anxious for their "fragile" baby. They will experience many of the usual feelings associated with the second psycholo-

gical postpartum stage.

It generally takes two years or more for a child born prematurely to "catch up" in his size and development. During this time parents may experience periodic feelings of guilt, inadequacy, and resentment as their child is compared to others of the same chronological age. It is important for the parents to remember that all infants progress at their own rate and in their own unique way.

Multiple Births

For the parents who experience the arrival of more than one infant simultaneously, the postpartum period poses a variety of unique features. Whether or not the birth of two or more babies has been anticipated may have some bearing on the psychological adjustment of the parents. Advanced warning can help the family prepare for the physical arrangements and extra help which will be necessary. The fatigue factor is a key to the parents' ability to cope with the demands made by the infants. While the stages of adjustment compare with those of one child, there is an additional emotional factor of trying to divide one's energies between more than one baby.

Parents of Handicapped Children

The parents of children born with chronic illness or disability react to the realization with a range of emotions which includes shock, disbelief, depression, anger, and denial. A period of parental mourning for the child who might have been is also common. The feelings of failure and guilt are often uppermost in the parents' minds. The postpartum period will be very difficult and it is important for these families to receive prompt pro-

fessional guidance. The Santa Barbara community is fortunate in having a wide availability of professionals and agenices which can deal with the parents' adjustments as well as the child's.

Parent-Child Separation

After the birth of an infant, a situation may occur where the baby is required to remain in or return to the hospital. This is apt to happen with premature babies, or when illness is present. The pediatrician will make the decision regarding the release of the baby from the nursery. An unexpected problem can have a strong emotional impact on the parents, particularly the mother. The bond between infant and parent is created early and interference with this natural process may lead to difficulties later. Hopefully, if the baby is separated from the parents, the hospital staff and facility will be flexible enough to allow frequent visits and to encourage as much physical contact as possible, especially with feedings. Breastfeeding can be continued through support from doctors, nurses and family. This disruption from the normal adjustment period adds another dimension to the emotions of postpartum stages one and two. The worry over an ill baby can compound other feelings and create further problems. Professional assistance may be necessary to ease the family through such experiences.

Belated Parenthood

There is a trend among some couples today to postpone their plans to begin their families. Whether parenthood is intentionally delayed for career or economic reasons, or happens accidentally, the emotional adjust-

ments may be unique. While many of the worries of delaying pregnancies have decreased because of improved pre-natal care, the parents may find that a type of cultural shock sets in during postpartum. Part of this problem is caused by the fact that one's friends often change with the birth of a child. In searching for companions for the child, the maturity levels and interests of other parents may not correspond with the older parents. Feelings of loneliness, alienation, or possible rejection by pre-childbearing acquaintances may occur. This situation may happen to first-time parents or to those who have a wide age gap between siblings. The generation gap worry may be more pronounced for some of these parents. This fear is not necessarily generated by the age difference, but may be the result of a psychological conflict for any parent at any age.

Single Female Parent

The number of mothers without mates who are creating their own family units is on the increase. The societal pressures for these women to place their babies for adoption have changed dramatically allowing them to continue pregnancies and become a single parent. Although each situation will differ, the postpartum period will most likely follow the previous general discussion of the three stages (see page 11.) The mother may live with her parents, with friends or be alone, and the adjustments will vary greatly depending upon circumstances. If the mother does not have additional persons in the family to care for, the stages may be easier since her total attention can be placed on the baby and herself. If, however, the mother needs additional support, both physically and emotionally, and there is none, then her experience may be more difficult. The maturity level of the single mother

is very important since she will be both father and mother to her child. Occasionally, the responsibilty of single parenthood becomes too great and the consequences may be to the detriment of the child and the parent. Professional guidance and additional outside assistance will help in these cases.

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SECTION II: THE FIRST YEAR

The second section deals with the developing child in his family environment by describing the categories of social, language, psychological and motor growth of the first year. Chapter 1 provides an outline of some of the common emotions of parents. Chapter 2 is devoted entirely to the child.

Chapter 1: Emotional Adjustments of Parents

As the child grows and develops, the parents as individuals and the family as a whole also grow and develop. The developmental process for all brings with it many problems and joys. Some of the most common of these are considered here as anaid for discussion topics and questions. The following format differs somewhat from the one chosen for the parents' feelings towards the immediate post-partum experience to allow for more depth in discussing these concerns. As stated before, the feelings considered will vary enormously from parent to parent and the only attempt that is being made here is to consider those which seem to be discussed most frequently.

Emotions	Parent's Reactions	Positive Aspects	Negative Aspects	Suggestions for dealing with these Emotions
Pride	The child is a part of them. As he develops they are proud of their accomplishments, real or imagined.	Being proud is a happy feeling. The child is providing something good for his parents.	Parents tend to talk too much about their child's accomplishments. They may become too involved in their child. Growing up is hard enough for one without the child having to be responsible for his parents' emotions.	Recognize that the child is an individual with his own needs. Try and place feelings in perspective. Make sure the mother has outside interests. When mothers stay home all day they often have little else to talk about beside their child and this contributes to being wrapped up in him.
Love	The child give loves and the parent responds.	Happiness	Sometimes a child appears nonaffectionate or is nonphysical in his love. The parents may feel something is wrong or they are inadequate.	Recognize individual differences and that some children like cuddling and others do not.

Emotions	Parent's Reactions	Positive Aspects	Negative Aspects	Suggestions for dealing with these Emotions
Being Needed	Sense of satisfaction and self worth at being able to mean so much to someone.	Feeling worthwhile.	Such need may become a burden which may seem impossible to relieve.	Get help sometimes. Get a babysitter and go out. Let the child be used to other people so the parents are not the only ones who can satisfy.
Frustration	Inability to carry out plans for daily living. Things often get out of control.	The parents learn to deal with many situations that arise.	Parents can easily become depressed or angry. Without proper outlets for these emotions, such feelings can be harmful to the child or themselves.	Discuss problems with others and attempt to seek solutions. Recognize that some amount of frustration is inherent in childraising and attempt to put it in perspective with the joy received.
Worry	Parents worry about the baby's safety and development, and they worry during the many little sicknesses that happen. They also worry about themselves and their ability to raise a family.	The worry may encourage them to seek solutions to their problems to alleviate their concern.	Parents' feelings can transfer to the child who may feel there is something wrong with him. Worry without problem solving actions is purely destructive. Too much worry may lead to panic and the inability to take positive action. Some overly protective parents worry over the safety of their child and inhibit the child's development by failing to permit the child to experience the environment.	Try to see how others have dealt with similar situations. Accept the child as he is and try to avoid comparing children. Place the child in reasonably safe environments and do not be concerned about minor scratches. Parents should do their best and leave it at that.

Emotions	Parents' Reactions	Negative Aspects	Suggestions for dealing with these Emotions
Jealousy	Another member of the family, still very demanding, means attention must be spread thinner.	Makes people unhappy.	Try to balance the time between all members of the family. Consider each member's needs and discuss them.
Inadequacy	Parents attempt to do the "right" thing for their children but translated into daily occurences the "right" thing is not always obvious. Inability to control the child's behavior also contributes to these feelings.	When parents feel good about themselves and seem to know what to do, the child feels secure and happy. The child needs guidance and the parents' feelings may stand in the way of giving the guidance needed.	Recognize that there is not one "right" way and that raising a child is a difficult job. Realize that a parent knows his own child better than anyone else and is in the best position to make decisions. Do not look for things that go wrong and assume blame. Parents need to do the best thay can and realize that is all a person can do.
Resentment	Too much time is demanded by the child. Dinners spoiled, spilled food, and crying are difficult. Resentment can occur as there appears to be no way to stop the problems.	The feelings can transfer to the child who may feel that he is doing something wrong when he cannot control the situation.	Recognize that some resentment from time to time is natural. Parents should take care of their <u>own</u> needs, realizing <u>every</u> member of the family is important.

In addition to these emotions and many others, one of the most common problems of parenthood is discipline. Much has been written about this subject with many different and often conflicting theories. Again, to provide some guidelines for discussion a few common worries about the subject are listed here. No attempt has been made to explore any theory or method.

Subject	Discussion
Individual Differences	Because each child is different, no one method or manner of dealing with situations will work reliably. Finding methods that lead to the most harmony with any one child is one of the parents' most difficult jobs.
Consistency	Almost all theories of discipline accept consistency as desirable to any effective method. It must be kept in mind, however, that absolute consistency is probably impossible and what is most likely meant is general consistency of overall guidelines of behavior and philosophy.
Difference of Opinion Mother-Father	Since knowing the "right" thing to do is almost impossible, differences of opinion are bound to arise. Such differences should be discussed and solutions arrived at, realizing that solutions will probably be compromises.
Housekeeping	Raising a child is difficult work. For peace of mind examining priorities and placing housework in perspective to childraising is very important. (See- Childproofing)
Spanking	Spanking shows the child that the parent is angry. Each parent will decide if, when, and how much spanking is necessary for the child. Some authorities believe that if it is used as the primary method of controlling behavior the child will probably learn to use similar methods of dealing with the problems he faces.
Parents as Models	The child learns from all he sees. The types of people the parents are and the lives they lead will probably have a significant effect on the child.
Parents as Guides	Sometimes in an attempt to promote creativity parents fail to give their child adequate guidelines. This often is unfair to the child. A misbehaving child is not liked by anyone, including himself.

Subject	Discussion
Child does not always behave as desired	Adults do not always behave as desired. If the child conforms to behavior considered reasonable most of the time, he is probably learning what the parents wish him to in regards to acceptable behavior.
Child Development	It is very important that the parents know what is reasonable to expect of a child at a given age. Many books are available to supply this knowledge without which it is difficult to make reasonable demands or set reasonable guidelines. After recognizing that the developmental guidelines discussed in these books are averages only and, as such, are subject to a wide degree of individual variation, parents can use them as a reference for developing their own parenting practices.

Husband-Wife Relationship

It is important to realize that much of the stress and tension that is experienced by the postpartum family is likely to extend well into the first year or even longer. Often a husband and wife may delay expressing or dealing with feelings of irritation or resentment, reassuring themselves that the situation is only temporary. Theyassume that eventually their lives and their relationship will return to the pre-baby state. It is essential, however, that the family come to the realization that their situation, and the relationships involved, have undergone permanent change.

As the first year progresses, the many aspects of this altered relationship become apparent. Basically the relationship can no longer be spontaneous. Everything, including the dinner together, going out to a movie, sex, or even a discussion, must be planned in consideration of the baby's schedule. And even then interruptions are the rule rather than the exception. Dealing with the physical and emotional demands put upon both husband and wife can leave them with very little energy reserve with which to work on rebuilding their own relationship.

Additional considerations can begin to develop after the initial postpartum period. Feelings of disappointment and resentment can build as new parents discover their differing expectations of each othere's role as father and mother. As the child develops, the parents may also discover that they have differing philosophies of child rearing. If the mother is breast-feeding, there may be disagreements concerning when to wean, as prolonged trips away together or even a evening out are difficult during the nursing period. The husband may also experience feelings of disappointment and resentment if his wife finds it difficult to seperate her role as mother and her role as wife; even when they have time alone together, she may find it hard to relax and enjoy herself, or may be too tired to do so.

All of these feelings vary in intensity and duration, but if ignored or left unexpressed, they may lead to deepening problems and greater rifts in the relationship. As months pass a wife may immerse herself in her role as mother; a father, continually finding his wife too tired or too "used up", may retreat into his work or other interests.

Renewing and revitalizing sexual expression is vital to re-establishing a close relationship. If initial attempts at intercourse are not satisfying or successful (due to birth discomforts, hormonal changes or tenseness), disappointment and frustration may lead to apathy. Both husband and wife must make a special effort to communicate to each other their feelings, needs, and fears. If a wife is fearful or reluctant about resuming intercourse perhaps a couple can re-evaluate their expectation that sexual expression must include intercourse. Initial sensitivity and understanding will do much to promote long term adjustments in the relationship. The first step in beginning to come to terms with the new husband-wife relationship is to

maintain open and honest communication. Expressing needs and feelings will help to free energy to be spent on re-establishing closeness as a couple. The sooner a husband and wife can acknowledge the permanent alterations that have taken place in their relationship, the sooner they will be able to make a committment to accept each other as they are now, and progress to building an even deeper and more satisfying life together.

There are some specific communication skills that may be used in promoting understanding and acceptance. Whenever possible, feelings should be expressed as they occur and should be statements of fact rather than judgements or accusations, i.e., "I feel as if I can't cope with this baby another minute!" rather that "Why don't you get up off your_____ and come and help me with this baby!" (sending "I" messages rather than "You" messages.) Sympathetic listening can let a husband or wife know that his spouse truly understands how he feels, i.e., "You really feel beat tonight. You'd like a few minutes to relax before starting dinner." These types of open and understanding communication can help to lessen tension and re-establish physical and emotional closeness. Energy can then be directed toward discovering ways of enjoying time together (little as it may seem), on communicating ways of meeting each other's sexual needs, on re-examining old patterns and role expectations, and on finding agreeable solutions in situations where needs or feelings are in conflict.

Chapter 2: The Developmental Child

All children go through different stages of development. Each child goes through the same general stages; however, he goes through them in his own way and on his own time schedule. The time spent in each stage will vary enormously. If the ages of all the babies developing any one skill were considered together, a trend (or average) would develop. A baby may develop one skill much earlier than the average; another may develop much later. Rather than compare the baby with the average, the parent would do well to compare the child with himself, as he has been in the past and as he might be in the future. The average is helpful in knowing the probable direction of changes the parent may expect as the child grows older. Generally, skills develop in one of four categories:

The Social category is a term used to describe the developing ability of the child to react to other people, adjust to domestic life and, ultimately, to social groups.

The Language category will describe the various stages through which the child progresses in order to learn to communicate with others. This includes both the ability to express oneself as well as understand what others say.

The Psychological category will describe the stages through which the child progresses in the development of a personality, a sense of self. The developing personality enablesprogression; from total dependence to independence.

The Motor category will describe the various physical changes occuring in the baby leading to general body co-ordination. This includes all

body activities from sight and hearing to walking and grasping. There are fine gradiations characteristic to each category, and early stages in their development may have little immediate visible relationship to the actual acquisition of that skill.

The following sections will briefly describe the child at various stages of development. When appropriate, special concerns and responsibilities of parenting will be discussed.

Birth to 6 Weeks

Bonding

The first hour is the optimum time for infant/parent bonding to start. Baby is awake and alert at that time. Talk to the baby together and encourage father/infant bonding. Lack of bonding or not allowing for it to occur can, in severe cases, lead to neglect or abuse.

Development

Social: Because of the dependent nature of an infant, the role of parent is vital to the infant's social development. Every time the parent comes in contact with the baby, be it through physical care or through holding and talking to it, the parent is helping to make the infant a social being. At this age social development overshadows the other developments and will influence their course.

The six week old infant can already distinguish between his parents and strangers. The smile as a social response appears between two and six weeks.

The baby interacts, socially by responding positively to comforts and satisfactions such as his parents soothing voices. The baby can also respond negatively (by crying) to such stimuli as the harsh voice of the parent.

Language: It is difficult to see that a newborn is developing language skills at six weeks. The baby will need to hear the spoken work for a very long time before hs will attempt to verbalize it. Talking, singing, and even reading by the parent contribute to language development. Any embarrassment that might occur from talking to an infant should be overcome because the spoken word is so vital to language development. Also, fathers should be involved so that the infant can associate the difference in pitch between parents.

Even at this early age, the baby communicates quite clearly. The newborn's language consists of small throaty noises and cries. The mother already can discern the different cries of hunger, fussiness, discomforts, and anger. The infant can also use facial expressions and body movements to show discomforts.

Phychological: The important development in this stage is the development of a sense of trust and this is accomplished by insuring that the newborn's needs are being met.

Motor: The skin is the major sensory and primary contact with the environment. The baby has a floppy head and at about one month, can lift the chin up. It is very important that the child not be too tightly bound and is allowed freedom of movement. The motor activity at this age is primarily reflexive. Reflexes are discussed under the Physical Newborn. The baby can see at or shortly after birth and can hear and respond to sounds whether pleasing or disturbing.

Stimulation

Sound: The human voice - speaking, singing, or reading

Musical toys or any toy that makes sounds

A clock

Skin: Patting, stroking, bathing, sunning

Exercise: Move the baby's arms, raise its legs, move them bicycling motion

Let the child grasp parent's fingers

Let the child "walk"

Visual: Mobiles (not within reach), printed sheets, wallpaper, bumper panels, mirrors, faces

Safety

Falls: An infant should never be left in an infant seat, on a changing table, or other place where he could roll off onto the floor. The parent should also be cautious when turning away, even momentarily. A playpen or an infant seat on the floor can be used when the parent is busy.

Auto Safety : The use of a car restraint should begin on the trip home from the hospital. Car restraints should meet federal standards. A car bed, if used in the rear of the car, should be securely fastened with a seat belt. Holding a child in a car or laying an infant on the front seat is dangerous.

Choking: An unattended, propped-up bottle is dangerous in that the infant may gag, spit up or cough with no one around.

Crib: The space between slats should not be big enough for an infants head to get stuck. Do not use pillows, constricting bedclothes, or a harness in the crib. Do not use paint containing lead for nursery walls or furniture.

Bath: To avoid burning the infant, test the water temperature. Do not leave an infant unattended in the bathtub. If the phone or doorbell interrupts the bath, the child should be taken out or the call ignored.

3 Months

The three month old baby will have more definite periods of sleeping, and being awake. He is no longer passive, but socially more responsive to people and is more active physically. Particular areas of interest during this age are:

Thumbsucking: Thumb sucking may have begun by three months. No mechanical means should be used to prevent this habit. Most babies will voluntarily give it up after varying periods of time. If baby is on a bottle, new nipples will help the baby get more sucking.

Drooling: Drooling is common at 3½ months of age. It indicates a greater production of saliva than the baby is able to swallow and is a normal condition.

Development

Social: The infant is becoming more interested in his surroundings, people and especially his parents. He enjoys having people near him as shown by his abundant smiles. He may smile at his own reflection and may laugh out loud.

Language: The three month old makes babbling and cooing sounds which may include the vowel sounds "ah", "eh", and "uh". He squeals and may start blowing bubbles. There is a definate effort to talk back when spoken to, which can be shown not only by a responsive sound, but also

by body movements and facial expressions. When the baby babbles and makes nonsense sounds, it is beneficial to make the same sound back. This pleases the baby and encourages the continuance of more sounds. Most parents do this naturally.

Psychological: Meeting the child's needs continues to help establish his senseof well being.

Motor: At three months the infant can follow a moving object from side to side with his eyes. His head has lost most of it's floppiness and is steady. When on his belly, the infant can lift his head and chest high. The infant has discovered his hands and likes to watch them. His hands are no longer tightly closed and he can get them to his mouth and hold a rattle. At the end of three months, he is beginning to reach for objects but misses. Compared to the six week old, the infant is much more active; he wiggles, kicks and squirms.

Sensory Stimulation

1. Rattles, squeaky rubber toys
2. Various things to feel: soft, hard, cold, rough.
3. A Texture Pad made up of fabrics of different textures.
4. Cradle Gym or similar home-made device.
5. Bells on booties.
6. Change in positions.
7. Music and noises.

Safety

Burns: Avoid smoking when caring for baby.

Toys: Select toys that are too large to swallow, with no small breakable parts and no sharp points. Be careful of older sibling's toys

which may be harmful to an infant.

Crib: Do not use a harness in the crib. Be sure the crib side locking mechanism cannot be accidently released.

Supervision: Infants should not be left alone in a car even for a few minutes. Infants should not be left with siblings under three years. The telephone number of the baby's doctor or emergency room of the hospital should be near the telephone.

Mobiles: Mobiles should now be moved out of baby's reach if not previously done.

6 Months

By six months, the baby is staying awake for longer "play periods." He enjoys banging and shaking things, throwing objects down, and putting everything in his mouth. He recognizes familiar faces and enjoys the company of others. He is more active and is more able to explore his environment. Particular areas of interest are:

Nutrition: At this age the baby is probably eating solid foods. There is considerable difference of opinion about when to introduce solids and which foods whould be introduced first. Each mother should follow her own doctor's instructions. One general rule is to introduce different foods one at a time to see if the baby reacts strangely. Make sure finger foods are such that the baby cannot bite off chunks big enough to choke on. Discussing any problems with the doctor and following the baby's individual needs are probably the best guides. Drinks from a cup may be offered at this age.

Teething: For some babies the appearance of teeth presents little problem and thus little problem for the parents. For others, however, teething seems to bring much discomfort and with it, crying that is very difficult for the mother to relieve. A few suggestions that might help at this time are giving the baby safe rubber teething toys, teething biscuits, or zwieback toast to chew. Rubbing the gums with a little whiskey and sugar, or putting an ice cube in a baby sock to chew may also be useful. Commercial teething preparations are not that helpful, but may be tried. One of the most helpbul aids is aspirin or actephamin (Tempra, Liquiprin) or a combination of the two. Check with the doctor for the correct dosage and frequency. For severe cases, the doctor may prescribe some medication. Most doctors agree that teething does not cause illness. However, many mothers notice that their baby often has a diaper rash, a congested nose, a slight cough, loose stools, diminished appetite or increased irritability. Teething may lower the body's resistance so that a baby is more susceptible to illness. If a baby is sick while teething it should not be shrugged aside as "just teething". The illness is real and should be given the same care as any other illness.

Some babies will have trouble with only a few teeth while others seem never to stop teething. This is possible, since teeth on the way may even cause trouble.

If baby refuses to nurse during teething, the nursing period can be broken into shorter periods with a continuation of solid foods and drinks from a cup. A baby on the bottle can have the nipple holes enlarged if he is experiencing discomfort.

The first teeth to appear are usually the lower front teeth, but if the teeth make their appearance elsewhere, it is not of concern.

Development

Social: The baby recognizes parents and usually smiles at people he knows. He can respond to facial expressions and different intonations in voices. He really seems to like being with people. Some babies indicate apprehension at the approach of strangers at this time.

Language: The baby laughs, coos, bubbles, gurgles and vocalizes vowels and consonants. Again, talking to the child is very important for his language development, both to provide stimulation and to encourage his efforts.

Psychological: As the baby begins to be able to do things for himself, parents need to begin their orientation towards letting the child develop independence. At six months this means letting a baby reach for a toy without handing it to him, letting him struggle to roll over or creep to a new place. Of importance is the attitude of letting the child develop as a person in his own right, while making sure his needs are met.

Motor: The baby can usually roll over by himself and move in some fashion. He can sit well with support and is able to reach and grasp a dangling toy using his thumb as well as his fingers. He can transfer objects from one hand to the other and examines them with all his senses working together. (At an earlier stage, an object in one hand would remain unnoticed if not brought in front of the baby's eyes.) Most objects go directly to his mouth for further examination and exploration. His mobility at this time, although limited (perhaps) to creeping and rolling, makes additional safety precautions necessary. (These will be considered under the section dealing with safety.)

Stimulation

Toys: a. Lots of different objects and textures

b. Small blocks

c. Squeeze and squeak toys

d. Teething toys

e. Any object the baby can safely feel and put in his mouth

Experiences: Play on different surfaces - grass, floors, rugs, sand

Sound: Rhythm games: pat-a-cake, peek-a-boo

Safety

Mobility: Once a baby is able to roll over he should not be left unattended on a bed, table, or any surface he could fall from. A baby can move quickly and even on the floor can roll or creep over near plugs or objects that might hurt him.

Equipment: a. Playpens are often used for safety at this age, although getting a child used to one before he can move about, usually causes less resistance.

b. High Chairs should be checked carefully for sturdiness. Many doctors recommend low feeding tables.

c. Crib mattress should be placed at lowest position before the child is able to stand.

Toys: Check all toys for any sharp places or parts which could be removed and choked on or swallowed by the baby. Check squeeze toys for metal whistles that could come out. Make sure rattles have no parts that could be detachable leaving a stick that baby might poke in his eye.

Childproofing

Childproofing means that an effort has been made to make an area as safe as possible for children. At the age of six months a child is becoming mobile, it is now his environment is not only expanded but becomes potentially dangerous. While the items below point out some areas of concern, it should be noted that each parent needs to consider his own child's personality, maturity and his own unique environment.

Kitchen - Laundry: The area under the sink is where most people keep cleaning supplies such as detergent, cleanser, drain cleaner, and disinfectants. It should be locked or its supplies moved to a completely inaccessible area. Lye and drain products are so dangerous that they need extra precautions or they should be discarded immediately after each use. Knives and breakables should be moved from lower cabinets. The trash can is also an area of potential danger. The handles of pots and pans should be placed so they face the rear of the stove. The electrical cords from small appliances should not hang over the counter within a child's reach. The stove, garbage disposal, diswasher and washing machines are dangerous and need to be made off limits. Plastic bags should be out of reach.

Dining Area: A long tablecloth is potentially dangerous in that a child can grab it and pull it down along with whatever is on the table. There are rubber protectors for the corners of dining room tables.

Livingroom: Electrical cords should be in good repair and the baby should learn early that they are off limits for chewing and pulling.

Electrical outlets that are not in use here and elsewhere should have plastic safety caps, tape or childproof outlets covering them. Ashes in a fireplace may be a problem.

Stairs: Stairs should have a gate at the top and bottom until the child can maneuver them safely.

Bedrooms: Medicine should not be kept at bedside. Perfume, deodorant and hair products are poisons. A child can use a drawer as a climbing step. In the baby's bedroom the crib should not be near the curtain cords.

Bathroom: If the child is bathed in the big tub, a rubber safety mat should be used. Radios and electric heaters should be far away from tub or sink. Medicines should be kept in a locked chest with child resistant containers whenever possible. A child resistant container is not child proof.

Den: Firearms should always be locked up and unloaded.

Adult supervision is necessary even though a house is childproofed. The parent should check rooms continually for small objects such as pins, buttons, coins, nuts, and paperclips that the child might put into his mouth. The parent also has the responsibility of supervising the child at other people's homes, as well as training a babysitter to be safety conscious. When the parent cannot supervise, the best place for the child is a playpen or a childproofed room with a gate.

Miscellaneous:

a. Safety locks, caps and other items can be purchased at hardware or childrens stores.

b. Syrup of ipecac can be obtained to be used with a doctor's

instructions.

c. Potentially dangerous times are when the parent is sick, when the child is hungry, or when the family is moving or traveling.

9 Months

Particular Areas of Interest

Diet: The baby is beginning to be interested in the spoon and cup, it is helpful to give him his own to play with while he is being fed. Most babies are on chopped table foods or commercial junior foods. Some may still prefer strained food. Drinks from a cup may be offered.

Separation Anxiety: Some nine month olds may begin to show separation anxiety but it is more common in the up coming months. The child may cry when the parent leaves a room or the house.

Miscellaneous: Shoes are not essential at this age except for protection from the weather.

Usually the baby will have two naps at this age: morning and afternoon.

Development

Social: Parents should continue to show love, affection and approval of their child to aid his social development. The child at this age enjoys being with his family and likes to play peek-a-boo and wave bye-bye. At this age, he is beginning to show different moods. He protests more when his parents leave and is reluctant to go to sleep because he does not want to be left alone.

Language: This is the beginning period of imitative speech and the child will begin efforts to duplicate sounds that he hears. The baby can make many sounds and will say "mama" or "dada" though not necessarily with meaning. He enjoys listening to his own voice, and is beginning to understand much of what is said. He responds to commands such as "no" and will respond to bye-bye by waving or crying.

Psychological: The nine month old is in the process of learning about himself and his relationship with the world around him.

Motor: The nine month old can sit well for long periods of time. He can get to a sitting position alone. He is crawling rapidly and may be into climbing. The baby is beginning to change from a horizontal to a vertical orientation. He may pull to a standing position and may walk when both hands are held or by holding onto furniture. He can hold a bottle, feed himself finger food, hold a spoon, and playfully drop objects for someone to pick up. He can pick up small and large objects and is beginning to grasp with thumb and forefinger. His eyes pursue objects that he drops.

Stimulation

Games:
a. "Where is baby?"
b. Where is your nose, mouth, etc?
c. Pat-a-cake, Peek-a-boo
d. This little pig went to market...
e. Imitating games; clapping, nodding, waving, etc.
f. How big is baby?

g. Hide object for baby to retrieve

h. Read simple nursery rhymes

i. Naming or labeling games

Toys:

a. Surprise box

b. Busy Bath

c. Busy Driver

d. Balls

e. Cardboard books

f. Household objects

Experiences: Give the baby freedom to explore.

Safety: See Childproofing section.

12 Months

By the time the child has reached a first birthday, he will have most likely tripled his birth weight and grown about nine inches. He is active and will no longer be still and quiet while he is awake. He has definate likes and dislikes and because of this, may have negative periods. Temper tantrums may begin at any time. When the child begins to walk, he will begin a period of new found independence.

Particular Areas of Interest

Walking: Though most children take their first steps at around a year, othersmay be slower. First children, heavy children, and

children who have been ill or had a bad fall are usually slower to begin walking. If the child is walking outside, he will need shoes for protection against hard surfaces and the weather. If the weather permits, going barefoot is beneficial.

Miscellaneous: Some children develop a fear of the bathtub at this age. A joint bath, bubbles, an attached shower hose, or continued sponge baths may be possible solutions.

Nap times may be shifting between one and two naps.

Toilet training at this age is not advised.

The child may be more choosy and less hungry at feeding time. If he can, the baby may enjoy feeding himself.

The child may show primitive cooperation in getting dressed.

Development

Social: Separation anxiety will appear usually when the child is left in an unfamiliar place and the parent leaves. Because of greater mobility the child is more self confident and shows interest in children, animals, and his environment. He will do things just to get the parent's attention. If laughed at, he will repeat his performance. He has a sense of humor and enjoys being chased. He responds to "no" but may playfully test parent's limits.

Language: Even though the one year old has minimal speech (around three words) he can understand much and can respond to his own name, his parent's intonation and familiar games. Though not speaking, he imitates many sounds. His jargon already has the intonation patterns of our

language and may sound like short sentences. He may point to objects in response to a cue word. His first words will be duplicated monosyllables such as mama, dada and papa. In the next few months, the production of words may not greatly increase, as he concentrates on walking.

Psychological: The child is learning to differentiate between self and others, and independence is emerging.

Motor: The year old can stand alone, walks when held by one hand, and may take his first steps. He enjoys throwing things down from a high chair or playpen. He can build a tower of blocks and throw or roll a ball. With his index finger, he is beginning to poke and pry. This is an active age in which the child seems to be getting into everything.

Stimulation

Activities and Games:

a. Walks in the neighborhood
b. Play with other small children
c. Drawer filled with toys and household objects
d. Naming game during dressing, playtime, feeding, etc., and on trips outside the home such as at the market
e. Nursery rhymes
f. Games with objects; Where is it?, Stacking, etc.

Toys:

a. Hammer and peg toys

b. Simple puzzles

c. Small wagon, chair

d. Large blocks

e. Sand box and sand toys

f. Water play

g. Pull and push toys

h. Stacking toys

i. Balls

j. Hard and soft books

Safety

Once walking, a child's exploration is no longer limited to one room. He can reach higher; open bottles, packages, drawers, and cupboards; and climb on chairs and stairs. At his age, a child needs almost constant supervision. Silence may indicate potential danger.

a. A first aid book in the medicine cabinet is a good precaution.

b. Although falls are common at this age and a child should not be overprotected, he should be removed from potentially dangerous situations.

c. Outdoor play area should be fenced and locked. The garden area should be cleared of poisons, fertilizers and sharp tools.

d. Child should not be allowed in the garage alone.

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